MDR Tracking Number: M5-04-0084-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 9-5-03.

The IRO reviewed office visits, myofascial release, traction, ultrasound, and electric stimulation from 9-5-02 through 1-29-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the medical necessity issues. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-18-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
9/16/03 11/19/03 12/6/03	99213 x 3	$68.00 x 3	$0.00	C	$48.00	Rule 133.307(g)(3)(A-F)	Requestor did not challenge carrier's denial rationale. Neither party submitted a copy of the negotiated contract. No review can be made at this time.
TOTAL		$204.00	$0.00				The requestor is not entitled to reimbursement.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at

the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 9-5-02 through 1-29-03 in this dispute.

This Order is hereby issued this 13th day of February 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

November 17, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-04-0084-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The patient's records indicate that he was injured on the job on ___ when he was pulling a door down on a tractor/trailer and felt a sudden onset of low back pain. He began treatment on February 15, 2002 and was treated with conservative care to include chiropractic and modalities. He continued care for an extended time and was referred for ESI therapy in September of 2002. The injection series consisted of injections on September 12th and 26th as well as October 9th. NCV studies were performed which indicated that there was a radiculopathy at the level of left L5 and bilateral S1. MRI indicated a lumbar disc herniation at the level of L5/S1. Peer review by ___ indicated that the reviewer believe the injury was nothing more than a sprain/strain which should heal in 4-10 weeks lacking any intervention.

DISPUTED SERVICES

The carrier has denied office visits, myofascial release, traction, ultrasound and electric stimulation as not medically necessary from September 5, 2002 through January 29, 2003.

DECISION

The reviewer disagrees with the prior determination regarding office visits (99213) and manual traction (97122).

The reviewer agrees with the determination for all other treatments rendered.

BASIS FOR THE DECISION

The requestor did perform manipulation in a reasonable manner during and following the ESI therapy that was rendered by the referral doctor. The manual traction also would be considered helpful in mobilizing the lumbar spine as well as helping to absorb edema from the lumbar disc region following an ESI treatment. These findings would be giving the patient the benefit of any doubt. While the patient was having difficulty resuming his prior work level, he also did have an injury which seems to be much worse than a simple sprain/strain. With reference to the passive treatment rendered along with the chiropractic adjustments and traction, the reviewer is unable to find any documentation which would indicate that passive care of that type was reasonable at this point in the treatment plan. As a result, that part of the treatment plan is considered to not be reasonable or necessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,